Schizophrenia is psychotic bipolar disorder? What a polarizing idea!

Henry A. Nasrallah, MD

A hundred years ago, Kraepelin[1] distinguished two types of "insanity" in his institutionalized patients: dementia praecox (later relabeled as schizophrenia) and manic-depressive illness (later relabeled as bipolar disorder. His dichotomy was based on differences in clinical features, course, and outcomes. But over the years, Kraepelin recognized and admitted that some patients have overlapping features, and he gradually accepted what is now seen as a continuum of psychosis[2] that "bridges" the pure forms of those two disorders.

I applaud Drs. Lake and Hurwitz (*page 42*) for highlighting the diagnostic and treatment errors in a bipolar patient with severe psychotic features who was misdiagnosed as having schizophrenia. Errors such as this were common with DSM I and II but declined with the more reliable diagnostic schemas of DSM III and IV. I am puzzled, however, by their leap to the radical conclusion that schizophrenia does not exist and that all patients diagnosed with schizophrenia have psychotic bipolar disorder. This is not as egregious as Szasz' absurd proclamation 4 decades ago that schizophrenia is a "myth," but it is a significant scientific "transgression," given the evidence that distinguishes schizophrenia from bipolar disorder.

Symptoms. Beyond a doubt, these two brain diseases have overlapping clinical features, pharmacotherapies, and even outcomes in a subgroup of patients. However, these diseases have major differences, as outlined in the accompanying table (*page 68*).

Brain anomalies. Neuroimaging studies indicate that schizophrenia is associated with more-severe and pervasive morphologic brain anomalies (dysplasia and hypoplasia) than bipolar disorder, although some bipolar patients have reduced cerebral and frontal volumes and marked cognitive deficits.[3] Progressive neuro tissue loss has been observed early in schizophrenia but not in bipolar disorder.

Recent genetic studies indicate that several genes are found exclusively in schizophrenia or in bipolar disorder cohorts,[4] but some are shared by both disorders and may be related to delusional symptoms.[5] Familial transmission appears to differ: transgenerational studies find an abundance of mood disorders in family members of bipolar probands but rel-

Dr. Nasrallah is professor of psychiatry, neurology, and neuroscience, department of psychiatry, University of Cincinnati College of Medicine.

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Table

Symptom differences between schizophrenia and bipolar disorder

Symptom	Schizophrenia	Bipolar disorder
Psychosis	Auditory hallucinations and bizarre delusions are more common	Grandiosity is more common
Paranoia	Occurs in both, but more systematic in schizophrenia	
Core psychopathology	Far more negative symptoms and cognition dysfunction	Far more mood lability and affective cyclicity
Thought disorder	Far more disorganized and derailed thoughts	More likely to have racing thoughts and flight of ideas
Between-episode interpersonal skills	Withdrawn, alogic, seclusive	Much more interactive and verbal

atively sparse occurrence of psychosis in families of probands with schizophrenia.

Treatment. There is no doubt that monotherapy with antipsychotics (old and new) has similar efficacy[6] in schizophrenia and bipolar mania (and even in bipolar depression, with some atypicals[7]). However, there is minimal, if any, evidence that monotherapy mood stabilizers (lithium or anticonvulsants) have any tangible efficacy in schizophrenia. Electroconvulsive therapy is remarkably efficious in all phases of bipolar disorder but of dubious, if any, lasting benefit in schizophrenia.

Course. Both the premorbid history and post-treatment functional outcome tend to be more favorable in patients with bipolar disorder than schizophrenia. Most patients with schizophrenia experience significant clinical, social, and vocational deterioration, compared with a relative minority of bipolar patients.

In summary, schizophrenia and bipolar disorder are clearly distinct in their pure forms, although many patients have varying mixtures of both. Schizoaffective disorder is one of the most extensively investigated. Although many scholars have studied schizoaffective disorder, the evidence defies lumping it with either end of the continuum.

I agree with Drs. Lake and Hurwitz that most cases of schizoaffective disorder, especially the "schizomanic" type, are probably bipolar disorder with severe psychotic features. To assert, however, that schizophrenia does not exist at all and should be reclassified as bipolar disorder with psychotic features would contradict a massive body of clinical and biological evidence. It would cause Kraepelin to squirm in his grave.

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